

**EIS-HHS-CMS-CMSS-1**

**January 31, 2023**

**2:00 pm CT**

Coordinator: Welcome and thank you for standing by for the CMCS All-State Call and Webinar. I'd like to inform all parties that your lines have been placed in a listen-only mode until the question and answer session of today's conference.

This call is also being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's Allstate Call In Webinar. I'll now turn to Dan Tsai, our Center Director, for opening remarks. Dan?

Dan Tsai: Thanks, Jackie. Hi, everybody. It is - we've got a lot going on. So thanks everyone too. So welcome to today's Allstate call.

We're first going to go through - we're joined by a colleague Marisa Beatley from CCIIO, who will share some exciting information about a temporary marketplace, exceptional circumstances special enrollment period, for individuals losing Medicaid and CHIP coverage as a result of unwinding. And that was all announced on Friday.

And following that, our team, CNCF Team, Sarah De Lone, Sarah O'Connor, Rory Howe, Ashley Setala and folks will provide an overview of the state health official letter we've released that goes through guidance on the new unwinding requirements in the omnibus.

And so that is obviously a very important piece of guidance as we head into Medicaid redeterminations and renewals. So we'll get into questions after that.

And we'll use a Webinar for today's call. So if you're not logged in we suggest you do so now because there will be slides.

And before we jump into the details, I'm sure folks have also seen that yesterday the president announced that the PHE, the COVID-19 PHE, will end on May 11. That has multiple implications for all sorts of things disaster SPAs, and appendix case and all sorts of things we've been discussing with folks on the entire other part of unwinding separate from the renewal piece.

And so we will have much more on that on our next all state call next Tuesday, so some more to come. Thanks for being with us. We appreciate everything folks are doing on the front lines.

It's certainly a very intensive time. And, well, I'll say it again on this, thanks. So I'm gonna turn it over to Marisa from CCIIO for marketplace special enrollment period updates. Marisa?

Marisa Beatley: Thank you. Good afternoon. Yes, so we just wanted to provide some more information about the guidance that we published last Friday, the 27th, regarding this upcoming unwinding period and the temporary Special Enrollment Period, or SEPs, that will be available during the unwinding period.

So beginning on March 31, 2023, and lasting through July 31, 2024, marketplaces on the federal platform will be providing additional flexibility for marketplace eligible consumers who are losing their Medicaid or CHIP coverage to enroll in marketplace coverage during and immediately following the end of the Medicaid Continuous Enrollment Condition unwinding.

So this flexibility will be provided by facilitating access on healthcare.gov to Special Enrollment Period or SEPs. We are referring to this temporary SEP as the unwinding SEP.

And just to go over some of the highlights of what is in the guidance, coverage will be effective the first day of the month after a consumer makes a plan selection. So for example, if I were to select a plan today my coverage would be effective as of February 1.

We also provide instructions on which application question consumers should answer and how to answer the question so that they trigger the unwinding step. And we also provide some details regarding CMS's outreach strategy to get the word out to consumers about this temporary SEP opportunity. So that will be a combination of media, press, working with our partners such as navigators, agents, brokers, assisters to ensure that consumers know about this SEP opportunity.

And finally, I just want to stress that consumers don't have to wait until their Medicaid or CHIP coverage is ending to come to the marketplace and submit or update an application. We are urging consumers as soon as they know when their last day of Medicaid and CHIP coverage will be that they come to the marketplace and submit an application at that time to mitigate any gaps in coverage. And I will pass the virtual mic over now to Jackie. Thank you.

Jackie Glaze: Thank you, Marisa. So next the CNCF team will provide an overview of the unwinding that was released last Friday. So I'll turn to Sarah deLone to start their presentation. Sarah?

Sarah De Lone: Great. Thanks, Jackie. Can you hear me?

Jackie Glaze: Yes.

Sarah De Lone: Terrific, thanks. Just wanna make sure. Hi everybody. We are very happy to provide you with an overview of the SHO that we released last Friday and to answer as many questions as we can.

We appreciate hearing all of your questions, so don't be shy. But any we cannot answer today, we will certainly take back so that we can come back on a future call or work with you one on one to get those questions answered.

So the SHO, and the deck for today's presentation, you know, attempts to address the full range of policy and operational areas for unwinding that are impacted by Section 5131 of the Consolidated Appropriations Act 2023, including changes to the Continuous Enrollment Condition, reporting requirements, new enforcement authority provided to CMS as well as implications for the effective and expiration dates of states 1902(e)(14) waivers.

Next slide, please. To provide just an overview of the SHO, this is a second in a series of guidance for states on the implications of Section 5131 of the CAA which makes significant changes to the Continuous Enrollment Condition and the availability of temporary FMAP increase that's authorized under Section 6008 of FFCRA.

The first guidance, as you recall, was the (SIB) we issued early in January with some key timelines and dates for deliverables for states. Importantly, the CAA did not impact the date that COVID-19 PHE ends, but as Dan said earlier, you know, the president has taken some action in that regard.

Next slide, please. Actually, two more slides, Ashley. So first, to give a little bit of an overview of changes to the Continuous Enrollment Condition for states claiming the 6008, you know, temporary FMAP increase.

So under the Consolidated Appropriations Act the end of the Continuous Enrollment Condition for claiming a temporary FMAP increase is no longer tied to the end of the Public Health Emergency. Instead, the Continuous Enrollment Condition ends on March 31 of this year.

This means that states can begin their unwinding period as early as Wednesday, February 1, by initiating renewals, in February, that may result in terminations on or after April 1, 2023. States must begin their unwinding period by initiating renewals, that may result in terminations, no later than April 30, 2023.

States have up to 12 months to initiate and 14 months to complete renewal for all individuals enrolled in Medicaid CHIP and the basic health program once the state's unwinding period begins. And of critical note, regardless of when a state begins to unwind, terminations of Medicaid eligibility may not be effective earlier than April 1 in any state claiming the temporary FMAP increase in the first quarter of this calendar year.

Next slide, please. The CAA also separates the end of the temporary FMAP increase from the end of the COVID-19 Public Health Emergency.

So regardless of when the PHE ends the temporary FMAP increase, under FFCRA extends through December 31 of this year with the amount of the FMAP increase phasing down beginning in April. And you can see from the chart what the phased down amounts are.

The CAA also establishes new conditions under a new Section 6008 of FFCRA for states to claim the temporary FMAP increase beginning in April, i.e., during calendar quarters two, three, and four of this year. And we'll be talking about those conditions next.

So next slide. And one more slide. Thanks. So at a high level this slide shows what conditions apply during each quarter of 2023. You can see that no changes to the existing conditions described in 6008(e) of FFCRA, there are no changes in the conditions for quarter one of this year.

For quarters two through four of this calendar year, beginning in April, all of the conditions in FFCRA 6008(b) continue to apply with the exception of 6008(b)(3), which is a Continuous Enrollment Condition, that obviously no longer applies after March 31.

And there is one modification to the condition in 6008(b)(2) relating to the premium maintenance of effort. And that change will provide states with more flexibility effective April 1 to increase premiums on individuals based on their changes in their circumstances. CMS will be providing additional guidance about the implications of that change for states.

In addition, CAA Section 5131, establishes three new conditions for states to claim the increased FMAP during quarters two, three, and four of this

calendar year. And so with that I'm going to turn it over to Sarah O'Connor, who is going to talk about those three new conditions. Sarah?

Sarah O'Connor: Thank you so much Sarah. So the first condition is that Section 6008(f)(2)(a) of the FFCRA and provides that in order to claim the temporary FMAP increase, after March 31, 2023, states must conduct Medicaid redeterminations consistent with federal requirements including any renewal strategy approved under Section 1902(e)(14)(a) waiver or other CMS authorized processes and procedures. Even if a state does not claim the temporary FMAP increase all states must comply with federal renewal requirements or be subject to corrective action discussed in detail later in this presentation.

Next slide, please. The specific federal renewal requirements states will need to comply with as a condition of claiming the enhanced FMAP require states to conduct ex parte renewals for all beneficiaries, send a pre-populated renewal form to MAGI beneficiaries, provide MAGI based beneficiaries with a minimum of 30 days and non-MAGI beneficiaries a reasonable period of time to return their renewal form and any requested information through any of the modes of submission described at 435.907A, which would be online, by phone, by mail, and in person.

Next slide, please. States must also consider all basis of Medicaid eligibility prior to terminating coverage, provide a minimum of ten days advance notice and fair hearing rights prior to terminating or reducing Medicaid eligibility, assess eligibility for other insurance affordability programs and transfer the individual's account to the appropriate program for individuals determined ineligible for Medicaid and reconsider eligibility without requiring a new application from MAGI based beneficiaries whose coverage is terminated for

failure to return their renewal forms or necessary information if the form or information is returned within 90 days.

Depending on the state's systems and processes states that are unable to comply with all requirements set forth in 435.916 may need to adopt multiple alternative strategies in order to claim the temporary FMAP increase after March 31, 2023. CMS will work with states unable to comply with the renewal requirements to implement renewal strategies to meet the conditions, such as 1902(e)(14)(a) waivers or other alternative policies and procedures.

Next slide, please. The second new condition is that Section 6008(f)(2)(b) of the FFCRA and provides that in order to claim the temporary FMAP increase after March 31, 2023, states must attempt to ensure that they have up to date contact information for each individual for whom it conducts a renewal by using the USPS National Change of Address Database, information maintained by a state health and human service agency or other reliable source of contact information.

States have broad discretion to determine which other sources of contact information are reliable for purposes of this provision, but states must document the sources and other processes used in their unwinding operational plan. The types of contact information states must attempt to update are beneficiary mailing address, phone number, and email address, which is why states may need to use multiple data sources and/or adopt multiple strategies in order to update all types of beneficiary contact information. Implementing a robust plan to obtain up to date contact information from multiple modes of communication will assist states in meeting the returned mail condition, which we will discuss in the next section of this presentation.

Next slide, please. The state's plan to obtain up to date contact information should ensure that the state has recent and reliable information or has recently attempted to obtain up to date contact information prior to initiating a renewal for an individual to minimize the possibility that the information in the case record has been outdated. For example, CMS would consider quarterly data matches with the NCOA database or adoption of the Section 1902(e)(14)(a) strategy involving managed care organizations providing updated beneficiary contact information to be a recent attempt.

The waivers could make it easier for the state to ensure that it has up to date beneficiary contact information from these, or other reliable data sources, without first having to confirm the change with the individual. We encourage states that do not currently have such an approved 1902(e)(14)(a) waiver to consider submitting a request to CMS for approval. Again, states must document in their unwinding operational plan the strategies and processes for obtaining up to date contact information for beneficiaries in order to demonstrate compliance with the condition.

Next slide, please. The return mail condition in Section 6008(f)(2)(c) of the FFCRA requires states to make a good-faith effort to contact a beneficiary using more than one modality prior to terminating enrollment whenever beneficiary mail is returned to the state agency in response to a redetermination of eligibility.

A good-faith effort to contact an individual using more than one modality means the state has a process in place to obtain up to date mailing addresses and additional contact information, such as phone numbers and email addresses, for all beneficiaries, and the state attempts to reach an individual whose mail is returned through at least two modalities using the most up to

date contact information the state has for the individual which could include a forwarding address if one is provided on the returned mail.

We note that the first piece of returned mail does not count as the first attempt to contact the individual. States have discretion in the types of modalities they use to satisfy the returned mail condition. And such modalities could include mail, telephone, email, text messaging, communication through an online portal, or other commonly available electronic means.

Next slide, please. The first step states must take when mail is returned is for the state to confirm that the address is correct. If the address listed on the original mailing contains an error, or is missing information such as an apartment number, the state must resend the notice to the beneficiary.

If the state receives mail with no forwarding address then the state must attempt to contact the beneficiary with two modalities including phone, email, or text messaging. If only one other mode is available, such as an email address, the state must use that one.

Mail returned to the agency with an in, or an out of state forwarding address, provides new information to the state. And although states are not required to send the returned mail to the forwarding address, doing so would represent one attempt to contact the beneficiary. If the state does not send the notice to the forwarding address, and does not have two other modes of contact, the state will need to document, in their unwinding operational plan, why it is unable to send the notice to the forwarding address.

Next slide, please. We understand that states may not have alternative contact information even with the process in place to attempt to obtain up to date contact information described in the previous section. A state that has that

process in place, but has no other contact information, will not violate the returned mail condition due to not reaching out to the beneficiary through another modality as long as the state has taken the recommended steps to reach the individual by mail, which would be by resending the notice to a corrected address, if applicable, and sending the notice to a forwarding address if one is provided and the state is able to do so.

States must document, in their unwinding operational plans, their process for undertaking a good faith effort to contact individuals using more than one modality prior to disenrollment on the basis of returned mail in response to a redetermination of eligibility.

Finally, we know through our conversations with states that there are questions about the timing of the returned mail and what to do if the mail is returned to the agency after a lag in time. We appreciate the question and are working on guidance taking into account the requirements in the CAA and the burden before states. So with that I will turn it to Rory Howe for the next section.

Rory Howe: Thanks, Sarah. Good afternoon, everyone. I'd like to provide an overview of some of the financial processes associated with drawing federal funds for the temporary FMAP increase.

So the first process that I'd like to talk about is drawing funds from your state payment management system account. So for states that do meet the conditions, that are described in the SHO letter and statute, we are using a similar process to the process that we used for the 6.2 percentage point increase under Section 6008 of the FFCRA.

So that process will work. We will issue a grant award if you're a state that meets the conditions and is requesting funding. That grant award letter will contain information regarding the conditions that are associated with the temporary FMAP increase.

And when you draw FFP, from your payment management system account, you will be attesting that you meet the conditions as described in the statute and associated guidance. And again, that process is essentially the same process that we've relied on for prior quarters for the FMAP increase under the FFCRA Section 6008.

Next slide, please. So in addition to drawing the FFP, from your payment management system account, the letter also provides some information about requesting the FFP through the CMS-37 quarterly budget request process, as well as claiming the FFP associated with the temporary FMAP increase on the CMS-64.

So it's important to note that states that meet the conditions that are interested in obtaining the funding through the CMS-37 process should indicate on their quarterly CMS-37 form that they are requesting FFP associated with the temporary FMAP increase and that they meet the conditions. We will be updating the CMS-64 through the Medicaid budget and expenditure system to ensure that states that meet the conditions and are interested in claiming the FFP associated with the increase can do so through the Medicaid budget and expenditure system.

Just a couple of reminders, you know, standard practices regarding increased FMAP claiming and the period of availability do apply. There's some information in the SHO letter there.

And then as a reminder we also will be conducting our standard oversight activities to ensure that state claims are accurate and allowable. And finally, we are certainly available, and plan to work with states, to will provide whatever technical assistance is necessary to ensure that you can claim the FFP associated with the increase to the extent that you meet the conditions. With that, I will turn it over to Ashley. Thank you.

Ashley Setala: Thanks, Rory. So, as you all know, the CAA added new reporting requirements for all states between April 2023 and June of 2024, and also requires CMS to make that data publicly - or make that data publicly available on a monthly basis.

And at a high level in the SHO we explain that the data elements that states must report to fulfill the CAA requirements are all included in existing data sets, including the unwinding data reports, the Medicaid eligibility and enrollment performance indicator data sets, (CMSIS), and for state-based marketplaces and basic health programs, the SBM priority metrics that are submitted to CCIIO on a regular basis.

States will be able to meet the requirements of the CAA by continuing to submit data through those existing reporting processes. So no new separate report will be needed to fulfill the CAA requirement. And the SHO also clarifies that CMS will report the marketplace metrics for states that use the federal platform, which includes FSM states as well as FBM states that are on the federal eligibility and enrollment platform.

So we won't talk through this table but in the SHO we include a table that identifies each CAA required reporting element and the existing data source and metrics that states will use to satisfy each requirement. So on this slide we

list the Medicaid and CHIP metrics. And then on the next slide we list the marketplace and BHP metrics.

In the SHO we also include links to the data dictionary for the various data sets. So if states have questions about any of the metrics, and their specifications, you can take a look at those supporting documents and then let us know if you have any follow-up questions or need technical assistance. And with that, I will turn things back to Sarah. Sarah, I think if you're speaking, you might be on mute.

Sarah deLone: Thank you, Ashley. Do it every time. Thank you. So I just wanted to give you a quick overview of the new enforcement authorities that are provided under, you know, by the CAA. These are in addition to the, you know, long-standing enforcement authority that CMS has under Section 1904 of the Act, but there are three new authorities for CMS that are provided.

First, is a reduction of FMAP for a state that does not satisfy the CAA reporting requirements, those 1902 TP reporting requirements, during any fiscal quarter beginning July 1 of this year through June 30 of 2024.

Second, CMS may require a state to submit and implement a corrective action plan if CMS determines that a state is out of compliance, either with the reporting requirements under the CAA and/or with federal eligibility or determination requirements. And this is for the period that begins April 1 of this year through June 30, 2024.

And finally, CMS may require a state to suspend some or all of the Medicaid terminations that are being made for procedural reasons if the state, you know, is subject to a corrective action plan until the state takes appropriate corrective action and/or CMS can impose a civil monetary penalty of not more than

\$100,000 for each day of noncompliance. And I'm going to turn it back to Sarah O'Connor, who's going to talk about the implications for Section 1903(14) waivers. Sarah?

Sarah O'Connor: Thank you so much, Sarah. So many states have asked about their approved 1902(e)(14) waivers that have an effective and/or expiration date that's linked to the end of the COVID-19 Public Health Emergency and not the end of the Continuous Enrollment Condition.

As a result, these waiver authorities may no longer align with the state's unwinding timelines. We have explained in the SHO that CMS will allow states to implement a modified effective date consistent with the guidance in the SHO, which is also outlined in this chart without needing to submit a revised request to CMS.

So essentially where an approved (e)(14), is tied to the end of the PHE, the state may use the end of the Continuous Enrollment Condition for March 31, 2023 in lieu of the end of the PHE. States do not need to send a request to CMS to make these changes and should document any change in the effective date - in their records and maintain a copy of the SHO letter. Any state wishing to elect a different effective date or end date not reflected in this chart should reach out to CMS for assistance.

Next slide, please. We'd like states to know that we are available to provide technical support and recognize that states may need to make programmatic and operational changes to eligibility and enrollment policies and systems to ensure compliance. It may be necessary for states to consider alternative strategies and mitigation plans to address a state specific issue.

We are available to discuss additional strategies to streamline processes in order to maximize coverage retention, create procedural terminations, and support states to reduce burden. States may contact their CMS state lead for assistance as they assess their areas of need, but as all of you may know by now these conversations are already underway, and we really appreciate the partnership. So with that, I'm going to turn it back to Jackie.

Jackie Glaze: Thank you Sarah, Sarah, Rory, and Ashley for your overview. We're ready to move to the state questions, so we'll begin by using the chat function.

So you need to begin inputting your questions at this point. And then we'll follow by taking your questions over the phone line. So Ashley, I'll turn to you because I see some questions already.

Ashley Setala: Yes, thanks, Jackie. The first question says, "For people that states evaluate for eligibility in March, April, and May and determine that they are ineligible for Medicaid, would the state need to move the people to the COVID testing group temporarily?"

Shannon Lovejoy: Hi, this is Shannon Lovejoy in CAP, and I can get us started. So there is still the requirement for people to be eligible in all basis and move individuals to any other group that they may be eligible for following the redetermination.

I think we will need to come back to discuss how that can be operationalized in states that have adopted the optional COVID group. So I think there will be more to come on how that can be operationalized.

Ashley Setala: Okay, thanks Shannon. The next question says, "Are states able to resume standard processes for members received on a PARIS match file? For example, if a PARIS match is received on May 1, 2023, and the member's

renewal is not until October 31, 2023, can the state act on the information received from PARIS and close out eligibility if the member fails to verify residency?

Sarah deLone: So this is Sarah deLone. I think, you know, until the Continuous Enrollment Condition ends the limitations on PARIS, so if the Continuous Enrollment Condition applies, the limitations on terminating when there's a PARIS match, you know, under the IFR would continue to apply.

You know, once the Continuous Enrollment Condition is done, you know, is over, then states would then return to following their - the normal process which requires, you know, reaching out to a beneficiary to make sure that they, you know, to sort of confirm whether or not they are still a state resident or not a state resident. So I don't know, Sarah O'Connor, if you would wanna add anything to that.

(Suzette): Hi Sarah, this is (Suzette). And maybe I can just jump in and say, it sounds like the way the question was phrased, that it might be a question about processing the change of circumstance. So it sounds like maybe the state wasn't adopting the IFC strategy, but was reaching out to verify residency.

The individual doesn't respond, but how does that process fit in with unwinding? And I didn't catch all of the details of the question. I would say - I would refer the state to our change in circumstance guidance in the unwinding SHO letters.

So maybe we could loop back with that state if they have more specific questions, we're happy to talk this through in more detail. Again, so sorry, it was a pretty detailed question. I didn't catch all of the steps in it, but I would refer you to our change in circumstances

Sarah De Lone: Thanks, (Suzette).

Ashley Setala: The next question says, "Please clarify regarding returned mail. If a state conducts text outreach prior to sending a packet in an effort to obtain updated contact information, but gets no response from the member, and then receives returned mail for that same individual with no forwarding information, can states close that individual without becoming noncompliant?"

Sarah O'Connor: And this is Sarah. I can get started. So the - there are two separate requirements. And the first described in the question regarding attempting to obtain up to date contact information is separate and apart from the returned mail condition.

So the state is required to obtain the up to date contact information prior to sending a renewal. So that is something that states should have a process in place in order to obtain that up to date contact information.

And then the requirements to use more than one modality to reach an individual whose mail is returned is separate and apart from that requirement to obtain up to date contact information. So to specifically try and answer that question, if the state has a process in place to obtain that information prior to sending the renewal, or the state has confirmed up to date contact information prior to sending the renewal, the state would nonetheless be required after receipt of that returned mail to follow the steps we walk through in that section.

(Suzette): So maybe I can add, which I think is in the presentation as well. So, you know, as long as the state has a robust plan in place to obtain that contact information the state then attempts when the mail is returned to reach out

through two additional modalities. But, for example, if the state wasn't able to, you know, to do - had all the things in place to try and get phone numbers, emails, and you don't have any more information to be able to reach out to that specific individual, then we would consider that you met the requirements.

Ashley Setala: Okay, thanks, (Suzette) and Sarah. The next question says, "When can we expect additional guidance to be released on 6008(b)(2)? Will the new guidance expand on allowing premiums to increase for individuals, or will it be something else?" And, "Is it okay to use the current SHO letter to move forward with a plan to allow individual premiums to increase or should we wait on further guidance?"

Sarah De Lone: Hi, this is Sarah De Lone. We are working, you know, to provide additional guidance, you know, as quickly as we can. We understand there are a number of states that are interested in, you know, resuming policies that would increase premiums - would result in increases in premiums on individuals.

So we're working on that. And we'll get that to you as expeditiously as possible. But in the meantime, if you are needing to move forward with any changes to your premium, you know, sort of implementation of your premium policies or changes to your premium structure, I would highly recommend reaching out to your state lead to set up time for a technical assistance call.

Ashley Setala: Thank you, Sarah. So I think we're ready to move to the phone line. So I'll ask (Calvin) if you could provide instructions to the participants to register their questions, and then if you could please open the phone lines.

Coordinator: Yes, thank you. At this time, if you would like to ask a question, please press Star 1 on your telephone keypad. Please ensure that your phone is unmuted and record your name at the prompt.

Again, that is Star 1 if you would like to ask a question. Please stand by for the first question. And I'm showing no questions at this time. Once again, please press Star 1 to ask the question.

Sarah De Lone: (Calvin), no questions?

Coordinator: No questions at this time.

Sarah De Lone: All right, we'll circle back then. So Ashley, I'll turn back to you. Thank you.

Ashley Setala: Okay. Thanks. The next question says, "Is CMS planning to verify the CHIP FMAP rates?"

Rory Howe: Hi, this is Rory Howell with the Financial Management Group. So, yes, we do plan to provide information regarding implications for the CHIP match rate based on the temporary FMAP increases beginning April 1 through December 31. I will say that the process works very similar to how it did for the 6.2 percentage point FMAP increase, but we can share state specific information as soon as it's available.

Ashley Setala: Thanks, Rory. The next question says, "Has the Money Follows the Person grant adjusted FMAP rate been published for the April through June 2023 quarter and beyond?"

Rory Howe: I don't know that we have published that rate at this point. That's something that we'll have to take back and reconnect with the group.

Ashley Setala: Okay, thanks. Then we have some additional returned mail questions. The first one says, "If, after a renewal is sent, the state sends two more contacts to different modalities prior to possible returned mail, does this meet the requirement for returned mail?"

(Suzette): Ashley, I'm so sorry. Can you repeat the question, please?

Ashley Setala: Sure, it says, "If, after a renewal is sent, the state sends two more contacts to different modalities, prior to possible returns mail, does this meet the requirement for returned mail?"

Sarah De Lone: I think we need to probably need to take that one back (Suzette).

(Suzette): Yes. Yes, that would be good. Thank you.

Ashley Setala: Okay, the next question says, "What is the state's obligation if the returned mail is received well after the case has already been closed? In this example, the state fulfills its obligation to receive updated contact information."

Sarah De Lone: I think that's another question that's been raised, Sarah and (Suzette), that we need to spend a little more time on, and so we need to take back. So I think in the scenario, Ashley, if I'm hearing the question right, the returned mail is delayed enough, but the state doesn't receive the returned mail until after it's, you know, followed this process for termination.

Ashley Setala: Yes.

Sarah deLone: So I think, yes, we'll need to take that one back.

Ashley Setala: Okay. The next question says, "If the agency uses one modality to attempt to contact and then also directs the MCO to attempt to contact the recipient, do we need to confirm that they utilize a different modality than the agency?"

Sarah deLone: So that's another one that we're hitting on all the questions that we weren't, didn't anticipate or weren't able to work through. You know, the statutory language refers to the state making an attempt, and so we need, you know, we're looking into whether or not, you know, an MCO, acting on behalf of a state, would satisfy that statutory requirement. So that's another one that we're going to need to take back.

Ashley Setala: Thank you, Sarah. So we'll move back to the phone lines just to see if we have any calls registered. So, (Calvin), could you, once again, provide instructions to the participants for registering their questions up on the phone lines?

Coordinator: Yes, thank you. Once again, if you would like to ask a question, please press Star 1 on your telephone keypad. Again, that is Star 1. And we do have a question from (Tammy Lemur). Your line is open.

(Tammy Lemur): Yes, thank you. Good afternoon. My question is a little bit different. It actually relates to level of care determinations for the h\Home-and-Community-Based-Waiver programs. Is there any guidance or timeline information for when those LOCD determinations happen?

Sarah De Lone: We may need to come back with a response on that. I'm not sure if we have anyone on the line to respond, but we will follow up.

(Tammy Lemur): Thank you.

Coordinator: And I'm showing no further questions at this time.

Sarah De Lone: Thank you, (Calvin). So, Ashley, do you see any additional questions?

Ashley Setala: Yes, we do have a few more. We have a question that says, "Does the returned mail contact need to be about the returned mail specifically or would a text that says, you have not completed your renewal, please do so by the due date, suffice as one modality of contact?"

(Suzette): I think, this is (Suzette), I think we can take that one back and maybe align with some other questions. So it sounds like this is one of the same questions, not understanding when that text happens, so it sounds like perhaps it is not in response to a return mail but in response to a renewal form not yet being returned, like, maybe it's a reminder to return the renewal form prior to the end of the eligibility period. So why don't we take that back?

Ashley Setala: Okay. We have a question that says, "During the unwinding are states permitted to transfer members from Medicare savings programs to Medicaid and/or Medicaid to Medicare savings programs? Specifically asking if this type of transition occurs prior to a member's scheduled renewal?"

Sarah De Lone: So I'm thinking, (Suzanne) and Shannon, this is asking about somebody who maybe experiences a change in circumstances that would result in their being moved to an MSP group, you know, losing full benefits and moving to an MSP group, but a full renewal hasn't happened. That's how I'm hearing the question. Is that how you're hearing the question?

Shannon Lovejoy: This is Shannon, maybe we can take this one back because I'm also not sure if it's tying into some IFC related pieces. Maybe we can get the question and take it back.

Sarah De Lone: That sounds like a good plan.

Ashley Setala: Okay, the next question says, "Colorado has continued to send and process renewals since March 2020. If there is a change in circumstance reported between April 1 and April 30, and they were determined eligible through a renewal within the last 12 months, does the state have to take negative action immediately potentially as of April 30 or can we wait until their upcoming renewal month or can we, yes, or can we wait to take action until after May 31 when the first terminations will begin?"

Sarah De Lone: Hi, Ashley, I'm so sorry. Can you repeat the beginning of the question? I think there's a lot there I'm trying to - if you don't mind repeating it again.

Ashley Setala: Sure. So the state has been sending and processing renewals since March of 2020. And I was asking, "If there is a change in circumstance reported between April 1 and 30th, 2023, and the person was determined eligible for renewal within the last 12 months, does the state have to take negative action immediately, potentially as of April 30 or can they wait until the upcoming renewal month or after May 31 when the first terminations begin?"

Shannon Lovejoy: So I'm going to maybe try to start with if the state wants to reach out again. So if this is a state that has been processing renewals, and is also acting on changes in circumstances, I think there's a couple of things.

One is the timing of when the state begins its unwinding period, because it'll need to make sure that it's taking final action on redeterminations and renewals that are occurring during the unwinding period. But then, you know, again if this is a state that has been keeping up with renewals, and is acting on changes in circumstances, if the individual is still within their 12 month

eligibility period when the state goes to act on the change in circumstance, the state may do that.

During unwinding, states also have the option to delay redetermining eligibility in circumstance and align that work with the renewal that the state intended to conduct during the unwinding period. So it may depend a bit on the timing of everything and how the state would want to handle that.

Ashley Setala: Okay, thanks Shannon. The next question says, "What if you know you have an outdated address from previous attempts to send mail? Can you use two other modes, for example, text, phone calls, or emails to satisfy the requirement?"

Sarah O'Connor: This is Sarah. I'm not sure if the requirement, that they're referring to, is the returned mail or the requirement to attempt to update contact information. I think I need a little bit more information if that state could reach out.

Ashley Setala: Okay. Then we have a follow-up question on PARIS. And it says, "If the continuous coverage requirement ends on April 1, 2023 wouldn't the original PARIS match guidelines resume, so states would reach out to the members to try to verify residency? Did CMS say we would need to wait until the members' renewal to act on this change in circumstance?"

(Suzette): I think we said we would take that PARIS question back, but I'm not sure if this question is slightly different. So maybe we could also take this question back.

And I think what I understood is that it has to do with a state that adopted the IFC strategy. But maybe, again, it would be helpful for us to see the question and be able to respond.

Ashley Setala: Okay, then it looks like we have one more question that says, "Will CMS be releasing guidance on the 12 month continuous coverage requirement for children?"

Shannon Lovejoy: Hi, this is Shannon in CAP. We are still working on all the other provisions of the CAA and do know that there was information in there related to (unintelligible) eligibility for children.

Jackie Glaze: Thank you, Shannon. So I did want to follow back up with the state that asked the question on the level of care, HCBS redeterminations, if you could reach out to your state lead with your question and your contact information, we'll follow back up with you.

So in closing, I do want to thank our presenters today. And looking forward we will provide the topics and invitations for the next call.

If you do have questions that come up before the next call, please feel free to reach out to us, your state leads, or bring your questions to the next call. So we thank you for your participation today and hope everyone has a great afternoon. Thank you.

[End]